KERN MEDICAL CENTER

Standard Policy/Procedure	Department: Collections			
KERN MEDICAL CENTER	Policy No. COL-IM-407	Effective Date: January 2007	Review Date: Sunset Date:	Page 1 of 3
Title of Procedure: Financial Screening Process				

PURPOSE: To provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance.

DEFINITION:

Medically Indigent Adult Program (MIA): A state funded program which provides assistance to individuals who may meet the guidelines for qualification related to their healthcare needs. Patients may qualify for MIA if they are not eligible for Medi-Cal, and they have no insurance and no means of support.

Disability Evaluation Determination (DED): Patients who are considered to have a long-term disability lasting 12 months or greater, and they are unable to be gainfully employed due to their illness. A physician's statement on the patient diagnosis must also accompany the Presumptive Eligibility Rating. DED reviews at the State level can take 4-18 months. Denials are usually made immediately (within 60 days).

Discount Program (AB 774) – A state mandated program which provides assistance to individuals who meet the guidelines for qualification related to their healthcare needs. Patients may qualify for the discount program if they are self-pay or underinsured. Patients may also qualify for MIA in addition to the AB 774.

FPL – Federal Poverty Level

POLICY:
Patients/guarantors are screened for Medi-Cal if there is no other source of funding. If there is no Medi-Cal linkage and patients/guarantors are self pay, patients are screened for MIA (Medical Indigent Adult) and/or Discount Program. If patients/guarantors are underinsured and have high medical costs, they Are screened for the Discount Program.

Attempts are made to screen patients prior to their outpatient clinic visit or diagnostic testing appointment. The financial counselor does not have the authority to cancel a clinic appointment, but the financial counselor will inform the patient when they are "not financially cleared".
For unscheduled inpatients and emergency department patients, the financial counselor will attempt to interview the patient during their visit. However, if the patient is discharged prior to an interview, the patient will be contacted regarding Medi-Cal, MIA, and Discount Program eligibility.

EQUIPMENT: Does not apply.

PROCEDURE:

1. KMC patients and guarantors will be notified of KMC Financial Assistance program in a number of ways:
   - Signage posted at each patient access area
   - Patient friendly letters given to patient/guarantor at time of every registration
   - Message on each statement mailed to the patient/guarantor

2. Patients are referred to the financial counselors by way of central scheduling, referral center, physician referral or self referral when an outpatient appointment is requested.

3. Inpatients and emergency department patients are referred to the financial counselors for screening at the time of service. The inpatient discharge list is reviewed daily to identify patients that may be discharged prior to financial screening. If a self-pay patient was not financially screened during their visit, a letter is sent offering assistance with a Medi-Cal, MIA and Discount Program application. (Refer to attached letter.)

4. A brief telephone or face-to-face screening is completed before a scheduled appointment is given to the patient. Screening is done to determine if the patient has any other funding available before the MIA or the Discount Program eligibility process begins.

5. Patients who are eligible for Medi-Cal will be referred to the Department of Human Services for completion of a Medi-Cal application. Patients are eligible for Medi-Cal if they meet the following criteria:
   - Under 21 years of age or over 65 years of age
   - Pregnant

- Blind or disabled
- Minor children in the home with deprivation of a parent

6. Patients who are not eligible for Medi-Cal are screened for MIA and the Discount Program. An appointment is scheduled for a face-to-face interview, and the patient is requested to bring proof of Kern County residency and documents relating to income and asset verification for the past 30 days.

7. Case management assists in the completion of the "Presumptive Eligibility and Special Treatment Programs Verification and/or "Physician's Statement" when a patient is eligible for DED.

8. Patients are interviewed as outlined on the screening flowchart. (Refer to attached flowchart.) A Financial Linkage Evaluation form is completed. (Refer to attached Financial Linkage Evaluation). Patients who do not bring required documentation are rescheduled for their screening interview.

9. Eligibility determination for MIA and discount programs will be based on a 6 month, or yearly basis, depending on income source:

    a. 6 month: All patients who are not on a set income
    b. Yearly: Patients on a set income such as widow's pension or Social Security Retirement.

10. The status of the financial screening is documented in HBOC and **MICRS** (Medically Indigent Care Reporting System)

11. Patients without a source of funding may be referred to Case Management for a determination of medical necessity. Based on this review, payment may be requested at the time of service for non-emergency or elective services.

12. MIA and Discount Program Retroactive Eligibility: The application for the MIA must be filed no later than 90 days from the date of services rendered. Applications for the Discount Program must be filed no later than 150 days from the date services are rendered. Applications not filed within these timeframes will not be considered valid without the patient/guarantor showing good cause as to the reason the application was not filed in a timely manner. Services incurred without a valid application are deemed payable by the patient/responsible party. Consult your supervisor when necessary.

13. When financial screening has been completed for the self-pay patients, notify the referring source (i.e., central scheduling, referral center, physician referral) so the outpatient appointment may be scheduled.

14. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to KMC. Interest free payment schedule will ordinarily not exceed 12 months in duration. In extraordinary circumstances, a payment schedule may extend with the approval of the collection department supervisor. However, interest will accrue on the accounts of qualified patients engaged in a long term payment plan as allowed by State law, but interest will not be charged to the account so long as the qualified patient follows the agreed to reasonable long term payment plan. In the event the reasonable long term payment plan is breached by a qualified patient, the full amount of the accrued but uncharged interest to date will be charged to the account.

15. Any collections from patients resulting an overcharge under the AB774 is returned with interest. Interest is calculated at Kern County one year average of interest apportionment for refunds.

16. KMC will not report adverse information to a consumer credit reporting agency or take civil action against the patient for nonpayment at any time prior to 150 days after initial billing. KMC will not send unpaid bills to any collection agency or other assignee unless that entity has agreed to comply with AB 774 requirements while a patient is attempting to qualify for eligibility or attempting in good faith to settle an outstanding bill.

17. KMC will require a signed agreement from any outside third party collection agency stating they will follow the Hospital's applicable policies and procedures regarding the collection of outstanding accounts of qualified patients under MIA or discount programs as applicable under AB774.

18. KMC will allow any outside third party collection agency to file lawsuits, legal remedies wage garnishments after securing judgment against qualified patients so long as the provisions of AB774, including the noticed motion provisions are followed when and as required. Nothing in this policy is meant to address lawsuits or legal remedies against non qualified Hospital Patients.

19. KMC will allow any outside third party collection agency to file abstracts against any property owned once judgement is rendered against a qualified patient to the full extent authorized by Federal and State law, including AB 774. Neither Hospital nopr it's outside third party collection agency will ever request a sale of a primary residence of a qualified patient pursuant to any filed abstract in accordance with the terms of AB774, however any abstract may be paid off from any equity the qualified patient has realized in the property upon a sale ofr refinancing of the propert to the full extend allowed by AB 774.

SPECIAL CIRCUMSTANCES: Does not apply.

EDUCATION: Does not apply.

DOCUMENTATION: Does not apply

ADDENDUMS:

I. Flow Chart: Patients Screened for MIA, Medi-Cal or Self-Pay
II. Letter: Medi-Cal , MIA and Discount Program Eligibility Determination
III. Financial Linkage Evaluation
IV. Share of Cost Information
V. Presumptive Eligibility and Special Treatment Programs Verification Physician's Statement
VI. Financial Assistance Program Eligibility Guidelines
VII. Financial Assistance Worksheet
VIII. Table for determination of financial assistance allowances

REFERENCES: Does not apply.

POLICY & PROCEDURE COMMITTEE APPROVAL N/A OWNERSHIP (Committee/Department/Team) Collections ORIGINAL 11/1994 REVIEWED, NO REVISIONS N/A REVISED 09/2006 APPROVED BY Collections APPROVED BY COMMITTEE N/A APPROVED BY CLINICAL PRACTICE COMMITTEE N/A DISTRIBUTION Collections REQUIRES REVIEW 09/2009 SUNSET DATE 09/2010	
Fred A. Plane, CFO Administrative Signature of Approval Date 2/5/08	Dept Manager Signature of Approval Date (if applicable)

Appendix A
Financial Assistance Program Eligibility Guidelines

1) Discount Programs are not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary procedures as defined in policy.

2) Each person requesting financial assistance must have a completed application

3) Proof of income must be provided. Recent pay stubs and/or income tax returns are considered acceptable proof of income.

4) An individual will be eligible for Discount Program based on the FPL The patient/guarantor may qualify as:
   a) Self-Pay Eligible Patient: Patients/guarantors that are without third party insurance, Medicaid, and those whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.
   b) High Medical Cost Eligible Patient: Patients/guarantors who are not self-pay patients and have out-of pocket medical expenses in the prior 12 months that exceed 10% of the family's income and do not otherwise receive a discount as a consequence of third party coverage. Validation of these healthcare costs may be requested. Patient's who have insurance and have a liability that is applied to discounted charges are not eligible.
      - Consider a patient with a $5000 deductible who obtains services for which the hospital's undiscounted charge is $4000. If the patient's coverage has negotiated an arrangement where the patient pays 60% of charges, the patient would be liable to the hospital for $2400. Under these circumstances, AB774 would not require that patient be allowed to apply for charity or discounted care. The patient would be eligible to apply for charity or discounted care if the patient was obligated to pay the billed charges of $4000.

5) KMC may request waivers or releases from the patient/guarantor authorizing the hospital to obtain account information from the financial or commercial institutions or other entities that may hold or maintain assets for verification; however this information may not be utilized for collection activities.
   a) Monetary assets shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans.
   b) Monetary assets of $10,000.00 or less may not be counted
   c) Monetary assets greater than $10,000.00 may be counted at 50 percent when determining eligibility.

6) Patient liability for the self-pay eligible patient will not exceed the average rate received by a government payor.

7) Patient liability for the high medical cost eligible patient will not exceed the difference of the amount received from the third party payor and the maximum rate from a government payor.

8) Patients who qualify for MIA with a Share of Cost and Discount Program (AB774) is responsible for the lesser of the SOC or the Medicare Reimbursement Rates for Emergency Services and Outpatient Service or the sliding scale of the Medicare Reimbursement Rates for Inpatient Services.

9) Self-pay patients receiving Emergency room or outpatient services who qualify for the Discount Program (AB774) have a monthly Share of Cost based on the FPL. The patient/guarantor are responsible for the either the monthly SOC or the monthly total of Medicare Reimbursement Rates whichever is less.

10) Self-pay patients receiving Inpatient services who qualify for the Discount Program (AB774) are responsible for the sliding scale of the Medicare Reimbursement Rate not to exceed a reimbursement percentage equal to 75% of charges.

11) Restricted Medi-Cal patients who receive non-emergent services will receive a100% Charity Care adjustment.

12) Restricted Medi-Cal patients who receive Emergent Services that are denied due to medical necessity will be submitted for 1011 funding. Any outstanding balance is adjusted off to Charity Care.

Appendix B
Patient Friendly Letter

Dear Patient/Guarantor:

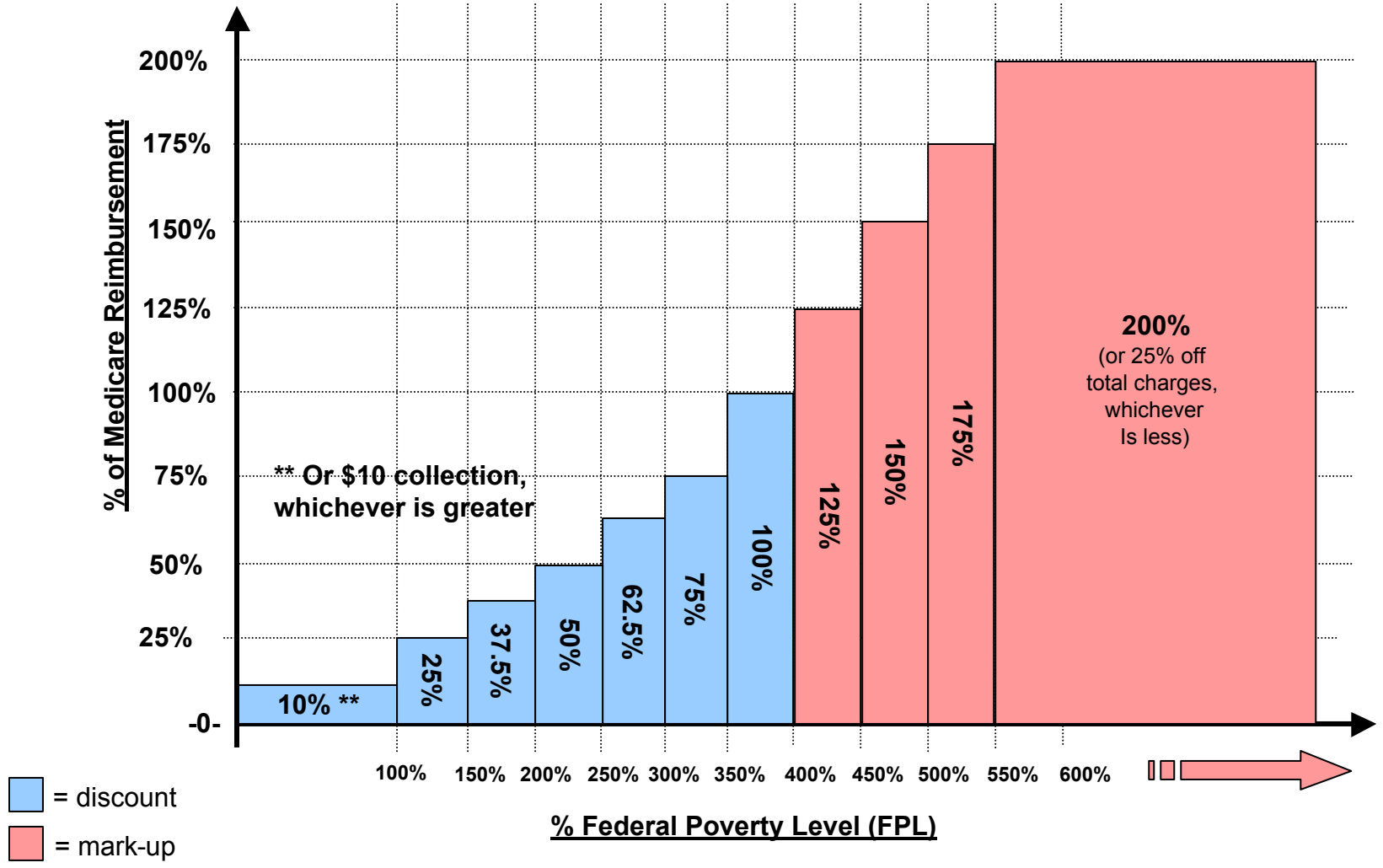
KMC is proud of its mission to provide quality care to all who need it regardless of ability to pay.

If you need assistance paying your healthcare bills, we may be able to help. If you do not have healthcare insurance or are underinsured, you may be eligible for one of our programs:

- Charity Care
- Discount Programs
- Medicare
- Medi-Cal
- California Children's Services
- Healthy Families

For more information, please contact our financial counseling office at 661-326-2392. We will treat your questions with confidentiality and courtesy.

Appendix C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